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<u>**Together for Quality Stakeholder Orientation Session**</u>   <u>**Glossary of Relevant Terms**</u>

Centers for Medicare and Medicaid Services (CMS): The CMS, through the Health and Human Services Administration, seeks to protect and improve beneficiary health and satisfaction; foster appropriate and predictable payments and high quality care; promote understanding of CMS programs among beneficiaries, the healthcare community, and the public; promote the fiscal integrity of CMS programs and be an accountable steward of public funds; foster excellence in the design and administration of CMS programs and provide leadership in the broader healthcare marketplace to improve health.

Certification Commission for Healthcare Information Technology (CCHIT): A group whose mission is to accelerate the adoption of robust interoperable HIT throughout the US healthcare system by creating an efficient, credible, sustainable mechanism for the certification of HIT products.

Chronic Disease Management: A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Clinical Decision Support System (CDS): Any system designed to improve clinical decision making related to diagnostic or therapeutic processes of care. CDS systems thus address activities ranging from the selection of drugs (i.e., the optimal antibiotic choice given specific microbiologic data or diagnostic tests) to detailed support for optimal drug dosing and support for resolving diagnostic dilemmas.

Clinical Messaging: The secure electronic transmission, between healthcare parties, of structured data that contains patient information.

Computerized Physician Order Entry (CPOE): A computer application that allows a physician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.

Continuity of Care: The process by which the patient and the physician are cooperatively involved in ongoing healthcare management toward the goal of high-quality, cost-effective medical care.

Doctor's Office Quality Information Technology (DOQ-IT): Promotes the adoption of electronic health record (EHR) systems and information technology (IT) in small-to-medium sized physician offices with a vision of enhancing access to patient information, decision support, and reference data, as well as improving patient-clinician communications.

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Document Management System: Document management systems are made up of software designed to manage all types of documents, including scanned, electronic, and paper. All documents are stored in a single repository that facilitates all actions that need to take place, from search and retrieval to e-mail and printing. A document management system implies the ability to manage the individual documents within an individual physician's office. It lacks, in general, the interconnectivity capabilities of both an EMR and an EHR.

Electronic Clinical Support Tool (ECST): The ECST will serve as *Together for Quality's* clinical decision support tool. The ECST will extract pertinent information out of the Personal Data Hub. The ECST is intended to include Medicaid's preferred drug list, generic and therapeutic options, prior authorization requirements, medication history and clinical support at the point-of-care. Advanced e-health functions to include the ability to e-prescribe and obtain a real-time response for prescriptions, as well as an electronic provider profile tool to include peer comparisons based on patient acuity and health outcome measures will also be included in the ECST.

Electronic Health Record (EHR): A real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. In *Together for Quality*, data from claims, immunization records, laboratory results and prescriptions will be used as the initial data set which, when pulled together for an individual Medicaid beneficiary, will be considered the electronic health record.

Electronic Health Record Vendor Association (EHRVA): HIMSS EHRVA is a trade association of Electronic Health Record (EHR) vendors that addresses national efforts to create interoperable EHRs in hospital and ambulatory care settings. The primary mission of the association is to provide a forum for the EHR vendor community relative to standards development, the EHR certification process, interoperability, performance and quality measures, and other EHR issues that may become the subject of increasing government, insurance, and physician association initiatives and requests.

Electronic Medical Record (EMR): A computerized practice management system providing real-time data access and evaluation in medical care. Together with clinical workstations and clinical data repository technologies, the EMR provides the mechanism for longitudinal data storage and access. A motivation for healthcare providers to implement this technology derives from the need for medical outcome studies, more efficient care, speedier communication among providers, and easier management of health plans.

Electronic Prescribing: A type of computer technology whereby physicians use handheld or personal computer devices to review drug and formulary coverage and to transmit prescriptions to a printer or to a local pharmacy. E-prescribing software can be integrated into existing clinical

information systems to allow physician access to patient-specific information to screen for drug interactions and allergies.

Health Information Exchange (HIE): The mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care.

Health Information Technology (HIT): The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision making.

Healthcare Information and Management Systems Society (HIMSS): The healthcare industry's membership organization exclusively focused on providing leadership for the optimal use of HIT and management systems for the betterment of human health.

Health Insurance Portability and Accountability Act (HIPAA): Enacted by the U.S. Congress in 1996. According to CMS, Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, the Administrative Simplification provisions, requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans, and employers.

Institute of Medicine (IOM): A nonprofit organization specifically created for this purpose as well as an honorific membership organization, the IOM was chartered in 1970 as a component of the National Academy of Sciences. The IOM's mission is to serve as adviser to the nation to improve health. The Institute provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large.

Interoperability: The ability to exchange and use information (usually in a large heterogeneous network made up of several local area networks). Interoperable systems reflect the ability of software and hardware on multiple machines from multiple vendors to communicate.

Master Patient Index (MPI): A software database program that collects a patient's various hospital identification numbers, perhaps from the blood lab, radiology, admission, and so on, and keeps them under a single, enterprise-wide identification number.

Office of the National Coordinator for Health Information Technology (ONC): Under the Department of Health and Human Services, the ONC provides leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of healthcare and the ability of consumers to manage their care and safety.

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Patient Data Hub (PDH): As a core piece of *Together for Quality's* health information system, the Alabama Medicaid Agency intends to develop an interoperable patient data hub (PDH). The PDH will serve as the foundational architecture for data exchange between all stakeholders, public and private, responsible for all facets of the health care delivery system, providing secure real time access to individual health information, claims, immunization records, prescription data and laboratory results. This system will pave the way for outcome based improvement of patient care and will provide significant components of data for Medicaid's future pay for performance and disease management efforts.

Personal Health Record (PHR): An electronic application through which individuals can maintain and manage their health information (and that of others for whom they are authorized) in a private, secure, and confidential environment.

Practice Management System (PMS): Part of the medical office record. It carries the financial, demographic, and non-medical information about patients. This information frequently includes the patient's name, patient's federal identification number, date of birth, telephone numbers, emergency contact person, alternate names for the patient, insurance company, subscriber information for an insurance company, employer information, information to verify insurance eligibility, information to qualify for lower fees, and provider numbers to process medical claims.

Quality Improvement Organization (QIO): Medicare QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure that patients get the right care at the right time, particularly among underserved populations. The program also safeguards the integrity of the Medicare trust fund by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about the quality of care. Under the direction of CMS, the program consists of a national network of 53 QIOs responsible for each U.S. state, territory, and the District of Columbia.

Record Locater Service (RLS): The Record Locator Service is the only new piece of infrastructure required by the Health Information Environment. The RLS is subject to privacy and security requirements, and is based on open standards set by the Standards and Policy Entity. The RLS holds information authorized by the patient about where authorized information can be found, but not the actual information the records may contain. It thus enables a separation, for reasons of security, privacy, and the preservation of the autonomy of the participating entities, of the function of locating authorized records from the function of transferring them to authorized users. RLSs are operated by multi-stakeholder collaboratives at each sub-network and are built on the current use of Master Patient Indices.

Results Delivery Service: A service that delivers clinical results from labs to the ordering clinician in the formats that he or she requires. Examples of results could include blood tests, immunology, pathology reports, X-ray, CAT scan, mammography, transcribed reports, etc. The service will deliver those results to the ordering physicians and to anyone else requiring a copy of those results.

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Regional Health Information Organization (RHIO): Multi-stakeholder organizations expected to be responsible for motivating and causing integration and information exchange in the nation's revamped healthcare system. Generally these stakeholders are developing a RHIO to affect the safety, quality, and efficiency of healthcare as well as access to healthcare as the result of health information technology.

Southern Governors' Association (SGA): A group that supports the work of southern governors by providing bipartisan, regional forums to help shape and implement national policy and to solve state and regional problems.

Use Case: A use case is a technique for capturing the potential requirements of a new system or software change. Each use case provides one or more scenarios that convey how the system should interact with the end user or another system to achieve a specific business goal. The use case should contain all system activities that have significance to the users. A use case can be thought of as a collection of possible scenarios related to a particular goal, indeed, the use case and goal are sometimes considered to be synonymous.